MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH FADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

873 (28)

Registration Dist. No. 28

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Beaumont (No. ..... , ... St.; ..... Ward)

2 FULL NAME Mary Maud Abell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) married

6 DATE OF BIRTH unknown (Month) (Day) (Year)

7 AGE 32 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) St. Marys Co

PARENTS

10 NAME OF FATHER Jos Samuel Norris

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Ann Abell

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna Spalding

(Address) Leonardtown Md

15 Filed Jan 7, 1920 Camalier
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 6th, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 27th, 1919, to Jan 6th, 1920, that I last saw her alive on Jan 5th, 1920, and that death occurred on the date stated above, at 3:00 pm.

The CAUSE OF DEATH * was as follows:

Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F F Greenwell M. D.

Jan 7th, 1920 (Address) Leonardtown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St Johns Cemetery

DATE OF BURIAL Jan 8th, 1920

20 UNDERTAKER Wm C Mattingly

ADDRESS Leonardtown Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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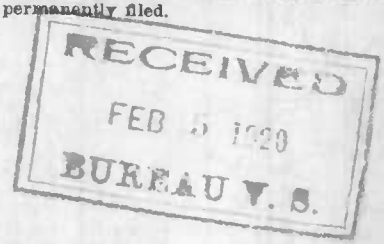

MARGIN RESERVED FOR BINDING

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

874 (91)

Registration Dist. No. 202

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Leonardtown (No. ____, ____ St.; ____ Ward)

2 FULL NAME Joseph Bright Pearfoot

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: Dec 1 (Month) (Day), 1890 (Year)

7 AGE: 29 yrs. 1 mos. ____ ds. If LESS than 1 day, ____ hrs. OR ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: farming
(b) General nature of industry, business, or establishment in which employed (or employer): "

9 BIRTHPLACE (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Westbrook Pearfoot

11 BIRTHPLACE OF FATHER (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Enid Pard

13 BIRTHPLACE OF MOTHER (State or country): North Carolina

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Westbrook Pearfoot

(Address) California Md

15 Filed Jan 20, 1920 Carruthers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 18 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1920, to Jan 18, 1920, that I last saw him alive on Jan 17, 1920, and that death occurred on the date stated above, at 8 a m.

The CAUSE OF DEATH * was as follows:

Pneumonia Bronchial

(Duration) ____ yrs. 1 mos. ____ ds.

Contributory / Secondary: Embolism, Cerebral

(Duration) ____ yrs. ____ mos. 1 hour ds.

(Signed) C A Brown, M. D.

Jan 20, 1920 (Address) Leonardtown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Ebenezer Church — DATE OF BURIAL: Jan 20, 1920

20 UNDERTAKER: Clement Mattingly — ADDRESS: Leonardtown

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work as well as (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*, (*a*) *Salesman*, (*b*) *Grocery*, (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*, *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident, Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
FEB 5 1920
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

875

(28)

Registration Dist. No. 280

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City St Inigoes (No. ....., ... St.; ..... Ward)

2 FULL NAME ~~George~~ John Henry Bennett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: black

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

6 DATE OF BIRTH: unknown (Month) (Day), 1859 (Year)

7 AGE: 71 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Oyster day
(b) General nature of industry business, or establishment in which employed (or employer): " "

9 BIRTHPLACE (State or country): St Marys Co. Md.

PARENTS

10 NAME OF FATHER: John Bennett

11 BIRTHPLACE OF FATHER (State or country): St Marys Co Md

12 MAIDEN NAME OF MOTHER: Henrietta Ann Clarke

13 BIRTHPLACE OF MOTHER (State or country): St Marys Co Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Son (Informant) Joseph Bennett

(Address) St Inigoes Md

15 Filed Jan 13, 1920 E. C. Birch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January (Month) 12 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1919, to Jan 12, 1920, that I last saw him alive on Dec 12, 1919, and that death occurred on the date stated above, at 8 p m.

The CAUSE OF DEATH * was as follows:

tuberculosis of lungs.

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Brown, M. D.

Jan 13, 1920 (Address) Leonardtown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Inigoes Church

DATE OF BURIAL: Jan 14, 1920

20 UNDERTAKER: E. L. Robinson

ADDRESS: Cameron Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichoemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetonus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

MARGIN RESERVED FOR BINDING

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(172)
876

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 287

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City California (No. ....., St; ..... Ward)

2 FULL NAME Rhody Bowens

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: December 18, 1893 (Month) (Day) (Year)

7 AGE: 26 yrs. 1 mos. ..... ds. If LESS than 1 day, .. hrs. OR .. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Saw mill

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Bowens

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah Lawrence

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John Bowens

(Address) California, Md.

15 Filed Jan 19, 1920 C Wesley Magall REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January 18, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1920, to Jan 18, 1920, that I last saw him alive on Jan 17, 1920 and that death occurred on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull, accidental, by falling on ice.

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P J Bean, M. D.

Jan 18, 1920 (Address) Jarboesville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: St. Andrews Church — DATE OF BURIAL: Jan 20, 1920

20 UNDERTAKER: Lewis T. Clarke — ADDRESS: Great Mills Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St, Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.. *Carcinoma. Sarcoma.* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis.* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse." "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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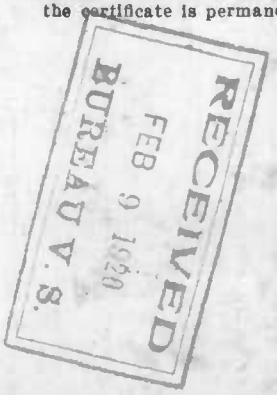

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

(92) 877

Registration Dist. No. 286

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Maddox (No. ....., ... Md St.; ..... Ward)

2 FULL NAME Samuel Brookbank

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH: Oct (Month) 14 (Day), 1858 (Year)

7 AGE: 62 yrs. 3 mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): Farming

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Samuel Brookbank

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Attaway Norris

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs W. C. Brady

(Address) 811 7th St. N.E. Wash. D.C.

15 Filed 1-27, 1920 R. V. Palmer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 23 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1920, to Jan 23d, 1920, that I last saw him alive on Jan 23d, 1920, and that death occurred on the date statod above, at 7 P. m.

The CAUSE OF DEATH * was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory
Secondary

(Dursition) ..... yrs. ..... mos. ..... de.

(Signed) Walter B. Dent, M. D.

1-24, 1920 (Address) Oakley Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In this State, ... yrs. ..... mos. ..... de.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Chaptico Cemetery — DATE OF BURIAL: Jan 26, 1920

20 UNDERTAKER: A. C. Welch — ADDRESS: Chaptico

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, perilonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED FEB 9 1904 BUREAU V.S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

878 (92)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 283

1 PLACE OF DEATH

County St. Mary's

Village or City Morganza (No. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Stephen Henry Bowles

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Wid.

6 DATE OF BIRTH: Feb. (Month) 6 (Day), 1835 (Year)

7 AGE: 84 yrs. 0 mos. 30 ds. | If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer (retired)
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm S. Bowles

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Polly Grey

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Bowles

(Address) Morganza

15 Filed Jan. 5, 1920 L B Johnson Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 5 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1920, to Jan 5, 1920, that I last saw h..... alive on Jan 5, 1920 and that death occurred on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 6 ds.

Contributory
Secondary ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L B Johnson, M. D.

Jan. 5, 1920 (Address) Morganza

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: St. Josephs | DATE OF BURIAL: Jan. 7, 1920

20 UNDERTAKER: B. B. Lore | ADDRESS: Morganza

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

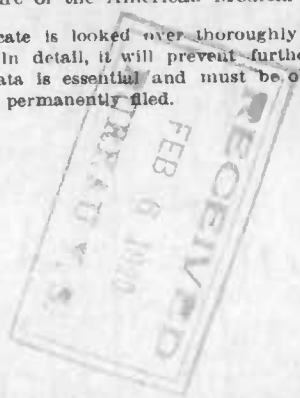
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.. *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH NON-FADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 286

879 (90)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Mary's

Village or City Oakley (No. ____, ____ Md St.; ____ Ward)

2 FULL NAME Mary Jane Burch

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Fem	White	Single

6 DATE OF BIRTH: Feb (Month) 8th (Day) 1842 (Year)

7 AGE: 77 yrs. 11 mos. — ds. If LESS than 1 day, ____ hrs. OR ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry business, or establishment in which employed (or employer): Teaching

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Albert Burch

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Amanda Turner

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss White Burch

(Address) Oakley Md

15 Filed 1-11, 1920 R V Palmer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 10 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 12th, 1919, to Jan 10th, 1920, that I last saw her alive on Jan 9th, 1920, and that death occurred on the date stated above, at 2:30 a m.

The CAUSE OF DEATH * was as follows:

Chronic Bronchitis, Arteriosclerosis with Thrombosis & senile gangrene involving entire foot.

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Walter B. Dent, M. D.

1-11-, 1920 (Address) Oakley Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Sacred Heart Cemetery — DATE OF BURIAL: Jan 12th, 1920

20 UNDERTAKER: A. C. Welch — ADDRESS: Chaptico Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for maliguant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED FEB 9 1920 BUREAU V.S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

880

(28)

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County St. Mary's

Registration Dist. No. 2 8 6

Village or City Bushwood (No. ..., Md St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Attaway Carter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) married

6 DATE OF BIRTH — — (Month) (Day) 1872 (Year)

7 AGE 48 yrs. — mos. — ds.

If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER William Carter

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Dorsey

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sherman Carter

(Address) Bushwood Md

15 Filed 1-26-1920 R. V. Palmer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 (Month) 26 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 12-20, 1919, to 1-26-, 1920, that I last saw her alive on 1-25-, 1920, and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. 6 mos. — ds.

Contributory Secondary

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. V. Palmer, M. D.

1-26, 1920 (Address) Abell Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sacred Heart

DATE OF BURIAL 1-27-1920

20 UNDERTAKER Welch Bros

ADDRESS Chaptico Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, ...ges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., *of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*, *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause to which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations in statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED FEB 9 1920 BUREAU OF

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 284

1 PLACE OF DEATH
County St. Marys
Village or City Orville (No. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Chase

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Black	

6 DATE OF BIRTH Jan (Month) 11 (Day), 1920 (Year)

7 AGE Still born yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER John Chase

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Katheleen Mabon

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEOGE

(Informant) .....

(Address) .....

15

Filed ....., 191 .....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 11 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,
that I last saw h..... alive on ....., 191...,
and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH * was as follows:

Still born

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leon J Jackson M. D.

Aug 20, 1920 (Address) Mechanicsville Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191...
20 UNDERTAKER	ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*, (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (avoid use of "Typhoid pneumonia"); *Lobar pneumonia* (avoid use of "Pneumonia," unqualified, or "Bronchopneumonia"). *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
NOV 5 1920
BUREAU V.S.
COPY SENT TO LOCAL REGISTRAR No. 284 DATE 10/20/20.
RECEIVED
AUG 23 1920
BUREAU, V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

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V. S. No. 1

881 (64)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2-8-6

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St. Mary's

Village or City Bushwood (No. ——, —— St.; —— Ward)

2 FULL NAME Louisa Clark

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
female	colored	single

6 DATE OF BIRTH —— (Month) —— (Day), 1880 (Year)

7 AGE 40 yrs. —— mos. —— ds. If LESS than 1 day, —— hrs. OR —— min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER William Clark

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Young

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adrian Clark

(Address) Bushwood Md

15 Filed 1-9-, 1920 N. V. Palmer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 (Month) 9 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 12-22-, 1919, to 1-9-, 1920, that I last saw h— alive on 1-7-, 1920, and that death occurred on the date stated above, at 2 a m.

The CAUSE OF DEATH * was as follows:

Cerebral apoplexy

(Duration) —— yrs. —— mos. 16 ds.

Contributory
Secondary

(Duration) —— yrs. —— mos. —— ds.

(Signed) N. V. Palmer, M. D.

1-9-, 1920 (Address) Leonardtown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sacred Heart — DATE OF BURIAL 1-10-, 1920

20 UNDERTAKER R. E. Cole — ADDRESS Oakley Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement. It should be used only when needed. As examples: (*a*) *Spinner.* (*b*) *Cotton mill;* (*a*) *Salesman.* (*b*) *Grocery;* (*a*) *Foreman.* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever write *None.*

Statement of Cause of Death. Name first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"), *Diphtheria* (avoid use of "Croup"), *Typhoid fever* (never report "Typhoid pneumonia"), *Lobar pneumonia, Bronchopneumonia.* ("Pneumonia" unqualified is indefinite); *Tuberculosis of lungs, Hemiplegia, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms), *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), Atrophy, "Collapse," "Coma," "Convulsions," Debility ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia,*" "PUERPERAL *peritonitis,*" etc. State cause to which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning. Struck by railway train—accident, Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU RECEIVED FEB 9 1920

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

882 (153)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 283

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH
County St. Marys
Village or City Helen (No. ____ St.; ____ Ward)

2 FULL NAME Wm Albert Countess

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Black	—

6 DATE OF BIRTH: Oct. (Month) 11 (Day), 1919 (Year)

7 AGE: ____ yrs. 2 mos. 3 ds. If LESS than 1 day, ____ hrs. OR ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

PARENTS

10 NAME OF FATHER Benj Countess

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Eleanor Holt.

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Benj Countess
(Address) Helen

15 Filed Jan-10, 1920 L. B. Johnson Local Reg. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. (Month) 10 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ____, 191__, to ____, 191__, that I last saw h____ alive on ____, 191__, and that death occurred on the date stated above, at 9 a. m.

The CAUSE OF DEATH * was as follows:
Paralysis - Lack of Care -
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) L. B. Johnson Local Reg. M. D.
Jan 10, 1920 (Address) Morganza

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St. Joseph's — DATE OF BURIAL: Jan 11, 1920

20 UNDERTAKER: Ignatius Butler — ADDRESS: Helen -

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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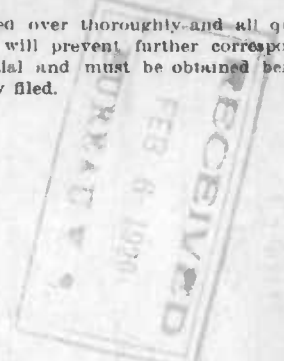

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 283

883 (120)

1 PLACE OF DEATH

County St. Mary's

Village or City Helen (No. ____, ____ St.; ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Josephine Bailey Ford.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F.	Colored	~~Widowed~~ Married

6 DATE OF BIRTH June 6, 1831 (Month) (Day) (Year)

7 AGE 88 yrs. 7 mos. 1 ds. If LESS than 1 day, ____ hrs. OR ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER James Young.

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Nellie Carter.

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edmund Young

(Address) Helen

15 Filed Jan. 6, 1920 L. B. Johnson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ~~Dec.~~ Jan. (Month) 5 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1919, to Jan. 5, 1920 that I last saw h alive on ____, 191 and that death occurred on the date stated above, at 7 a. m.

The CAUSE OF DEATH * was as follows:

Chronic Parenchymatous Nephritis

(Duration) 6 yrs. ____ mos. ____ ds.

Contributory Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) L. B. Johnson, M. D.

Jan. 6, 1920 (Address) Morganza

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Joseph's — DATE OF BURIAL Jan. 7, 1920

20 UNDERTAKER Wilbert Bros. — ADDRESS Chaptico

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1.

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MARGIN RESERVED FOR BINDING

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[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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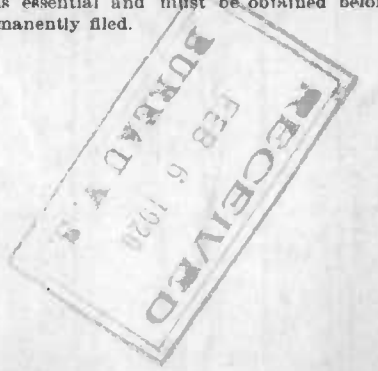

MARGIN RESERVED FOR BINDING

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

884 (137)

Registration Dist. No. 282

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Leonardtown (No. ..., ... St.; ..... Ward)

2 FULL NAME Lucy Gladen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: May 29 - 1900 (Month) (Day) (Year) Unknown

7 AGE: 19 yrs. 8 mos. — ds. If LESS than 1 day, ... hrs. OR ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: unknown
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): St Marys Co Md

PARENTS

10 NAME OF FATHER: George Gladen

11 BIRTHPLACE OF FATHER (State or country): St Marys Co Md

12 MAIDEN NAME OF MOTHER: Mary Biscoe Unknown

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alfred Gladen

(Address) Leonardtown Md

15 Filed Jan 29, 1920 Camalin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan 28, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1920, to Jan 28, 1920, that I last saw her alive on Jan 27, 1920 and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH * was as follows:

Puerperal Septicaemia

(Duration) ... yrs. ... mos. ... ds.

Contributory Secondary: Hystoria

(Duration) ... yrs. ... mos. ... ds.

(Signed) F F Greenwell M. D.

Jan 28, 1920 (Address) Leonardtown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. 3 ds. In the State, 19 yrs. 18 XX mos. ... ds.

Where was disease contracted, if not at place of death? Hermansville

Former or usual residence: Hermansville Md

19 PLACE OF BURIAL OR REMOVAL: St Nicholas

DATE OF BURIAL: Jan 29, 1920

20 UNDERTAKER: Joseph Biscoe

ADDRESS: Hermansville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified. is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 5 1920
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

885 (8)

Registration Dist. No. 282

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Marys

Village or City Leonardtown (No. ....., ... St.; ..... Ward)

2 FULL NAME Infant Gladen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) —

6 DATE OF BIRTH Jan 26, 1920 (Month) (Day) (Year)

7 AGE — yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER Lucy Gladen

13 BIRTHPLACE OF MOTHER (State or country) St. Marys Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Collins

(Address) Leonardtown Md

15 Filed Jan 26, 1920 Camalin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 26th, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1920, to Jan 26, 1920 that I ~~last~~ saw her ~~alive~~ dead on Jan 26, 1920, and that death occurred on the date stated above, at — m.

The CAUSE OF DEATH * was as follows:

Dystocia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory Secondary Maternal Deformity of Pelvis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F T Greenwell M. D.

Jan 26, 1920 (Address) Leonardtown

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St Aloysius Cemetary

DATE OF BURIAL Jan 26, 1920

20 UNDERTAKER John Gordon

ADDRESS Leonardtown Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified. is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
FEB 5 1920
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY. WITH NONFADING INK - THIS IS A PERMANENT RECORD

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified Exact statement of OCCUPATION is very important See instructions on back of certificate

V. S. No. 1

STATE OF MARYLAND
CERTIFICATE OF DEATH

886 (D)

Registration Dist. No. 252

1 PLACE OF DEATH

County St. Marys

Village or City Leonardtown (No. ..... , ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ignatius Hayden

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6 DATE OF BIRTH Jan 14 (Month) (Day) 1920 (Year)

7 AGE 0 yrs. 0 mos. 0 ds. If LESS than 1 day, ... hrs. OR ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Leonardtown Md

PARENTS

10 NAME OF FATHER Ignatius Hayden

11 BIRTHPLACE OF FATHER (State or country) Leonardtown Md

12 MAIDEN NAME OF MOTHER Martha Thompson

13 BIRTHPLACE OF MOTHER (State or country) Valley Lee

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ignatius Hayden

(Address) Leonardtown

15 Filed Jan 14, 1920 W. Barnacin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 14, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..... 191 , to — , 191 , that I last saw h alive on ..... , 191 , and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH * was as follows:

Pneumonia (4 mos.)

(Duration) ... yrs. ... mos. ... ds.

Contributory Secondary .....

(Duration) ... yrs. ... mos. ... ds

(Signed) Frank A. Engelhart M D

Jan 14, 1920 (Address) Leonardtown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds In the State ... yrs ... mos ... ds.

Where was disease contracted.

If not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Home

DATE OF BURIAL Jan 14, 1920

20 UNDERTAKER Ignatius Hayden

ADDRESS Leonardtown

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

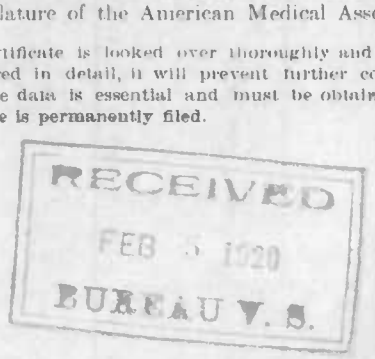
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*, (*a*) *Salesman*, (*b*) *Grocery*, (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Clerk," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*, *Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

887

(79)

Registration Dist. No. 2 82

1 PLACE OF DEATH

County St Marys

Village or City New Mechanicsville (No. ____, ____ St.; ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Maude Herbert

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	W	S.

6 DATE OF BIRTH ____ (Month) ____ (Day) 1871 (Year)

7 AGE 49 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Nurse
(b) General nature of industry business, or establishment in which employed (or employer) ____

9 BIRTHPLACE (State or country) St Marys Co.

PARENTS

10 NAME OF FATHER Jos. S. Herbert.

11 BIRTHPLACE OF FATHER (State or country) St Marys Co

12 MAIDEN NAME OF MOTHER Mary Jane Madrigal

13 BIRTHPLACE OF MOTHER (State or country) St Marys Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Olen Herbert

(Address) Hughesville

15 Filed Jan 30th, 1920 Lem Jackson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 29 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1915, to Jan, 1920, that I last saw h[er] alive on Jan, 1920, and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH * was as follows:

Valvular Heart disease

(Duration) 10 yrs. ____ mos. ____ ds.

Contributory Secondary Arterio Sclerosis

(Duration) 2 1 yrs. ____ mos. ____ ds.

(Signed) Lem Jackson, M. D.

Jan 31, 1920 (Address) Mechanicsville

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Joseph's Cemetery	Jan 31, 1920
20 UNDERTAKER	ADDRESS
A E Welch	Chaptico

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

RECEIVED
FEB 5 1953
BUREAU V. S.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 287

888 (25)

1 PLACE OF DEATH

County St Marys

Village or City Red Gate (No. ____, ____ St.; ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Hayden Hopkins

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY should state CAUSE OF DEATH in plain terms, so that it may be properly classified Exact statement of OCCUPATION is very important See instructions on back of certificate.

V. S. No. 1.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
female	black	widowed

6 DATE OF BIRTH: unknown (Month) 1 (Day) (Year)

7 AGE: about 70 yrs. unknown mos. ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farm laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): St Marys co Md

PARENTS

10 NAME OF FATHER: Robt Hayden

11 BIRTHPLACE OF FATHER (State or country): St Marys co Md

12 MAIDEN NAME OF MOTHER: Elizabeth unknown

13 BIRTHPLACE OF MOTHER (State or country): St Marys Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Henry Hayden

(Address) Red Gate Md

15 Filed Jan 19, 1920 Caroline Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January 17 (Month) (Day) 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1919, to January 17, 1920, that I last saw her alive on Jan 13, 1920, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH * was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 2 mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Jan 19, 1920 (Address) Leonardtown.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs mos ds
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Cartadys Chapel — DATE OF BURIAL: Jan 19, 1920

20 UNDERTAKER: Clement Mattingly — ADDRESS: Leonardtown

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationory fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons eugaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetonus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 5 1920
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1.

889 (92)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 283

1 PLACE OF DEATH

County St. Mary's

Village or City Loveville (No. ..., St.: ..., Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary J. Love

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: Mch. (Month) 4 (Day), 1845 (Year)

7 AGE: 74 yrs. 10 mos. 14 ds. If LESS than 1 day, ... hrs. OR ... min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Benedict Bond

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Readmond

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Love

(Address) Morganza

15 Filed Jan. 19, 1920 J. B. Johnson Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. (Month) 18 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1920, to Jan. 18, 1920, that I last saw h.. alive on Jan. 18, 1920, and that death occurred on the date stated above, at 2 p. m.

The CAUSE OF DEATH * was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 5 ds.

Contributory Secondary ... (Duration) ... yrs. ... mos. ... ds.

(Signed) J. B. Johnson, M. D.

Jan. 18, 1920 (Address) Morganza

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St. Joseph's — DATE OF BURIAL: Jan. 20, 1920

20 UNDERTAKER: Elmer Jarboe — ADDRESS: Helen

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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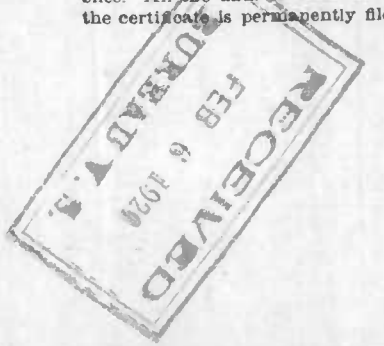

MARGIN RESERVED FOR BINDING

WRITE PLAINLY. WITH UNFADING INK - THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

890 (28)

Registration Dist. No. 282

1 PLACE OF DEATH

County St. Mary's

Village or City Leonardtown (No. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charlotte Milburn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): —

6 DATE OF BIRTH: ..... (Month) ..... (Day) 1896 (Year)

7 AGE: 28 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Lewis Milburn

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Milburn

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Milburn

(Address) Leonardtown

15 Filed Jan 31, 1920 Camacho

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 28 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1920 to Jan 2, 1920 that I last saw her alive on Jan 2, 1920 and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH * was as follows:

Tuberculosis pulmonary

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory Secondary .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A C Brown, M D

Jan 28 1920 (Address) Red Gate

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: New Town

DATE OF BURIAL: Jan 30, 1920

20 UNDERTAKER: W. C. Mackenzie

ADDRESS: Leonardtown

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*. (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager." "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
FEB 5 1920
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

891 (79)

Registration Dist. No. 284

1 PLACE OF DEATH

County St Marys

Village or City Oraville (No. ..... , ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Petrick

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): M

6 DATE OF BIRTH: ~~125~~ Doub Know (Month) (Day), 1858 (Year)

7 AGE: 62 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Germany

PARENTS

10 NAME OF FATHER: Doub Know

11 BIRTHPLACE OF FATHER (State or country): —

12 MAIDEN NAME OF MOTHER: Doub Know

13 BIRTHPLACE OF MOTHER (State or country): —

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Bostel

(Address) Mechanicville

15 Filed Jan 31, 1920 Lewis J Hoskins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: About Jan (Month) 28 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Forced, 191 to dead, 191 ,

that I last saw h ..... alive on ....., 191 ,

and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH * was as follows:

Examination & history indicated Valvular heart disease (Duration) ..... yrs. ..... mos. ..... ds.

Contributory Secondary .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lewis J Hoskins, M. D.

Jan 31, 1920 (Address) Mechanicville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State, ... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: All Faith Church

DATE OF BURIAL: Jan 31, 1920

20 UNDERTAKER: Elmer Jarbos

ADDRESS: Mechanicville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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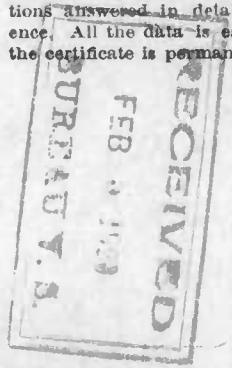

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH NON-FADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

892 (166)

Registration Dist. No. 280

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St. Marys

Village or City St. Inigoes (No. ____, ____ St.; ____ Ward)

2 FULL NAME Marie Sanders

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colr.

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July (Month) — (Day), 1917 (Year)

7 AGE 2 yrs. 6 mos. — ds. If LESS than 1 day, ____ hrs. OR ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md.

PARENTS

10 NAME OF FATHER Willie Sanders

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Sadie Montague

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Willie Sanders

(Address) St. Inigoes

15 Filed Jan 1 - 1920 E. E. Brick REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. (Month) 1 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from —, 191__, to —, 191__, that I last saw h— alive on —, 191__, and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH * was as follows:

Burned to death

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary Home Burning

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) E. E. Brick Corp. Reg.

Jan 1 - 1920 (Address) St. Inigoes Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Inigoes Md. DATE OF BURIAL Jan 1, 1920

20 UNDERTAKER Willie Sanders ADDRESS St. Inigoes

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer. Farm laborer, Laborer —Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY should state CAUSE OF DEATH in plain terms, so that it may be properly classified Exact statement of OCCUPATION is very important See instructions on back of certificate.

V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 281

893 (10)

[1] PLACE OF DEATH

County St. Mary's

Village or City Drayden, (No. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

[2] FULL NAME Brewster Sommerville

PERSONAL AND STATISTICAL PARTICULARS

[3] SEX: Male

[4] COLOR OR RACE: Colored

[5] SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

[6] DATE OF BIRTH: Oct. 18, 1902

[7] AGE: 18 yrs. — mos. — ds. If LESS than 1 day, ... hrs. OR ..... min.?

[8] OCCUPATION
(a) Trade, profession, or particular kind of work: Farm Laborer
(b) General nature of industry business, or establishment in which employed (or employer): .....

[9] BIRTHPLACE (State or country): St. Mary's County, Md.

PARENTS

[10] NAME OF FATHER: Henry Sommerville

[11] BIRTHPLACE OF FATHER (State or country): St. Mary's County, Md.

[12] MAIDEN NAME OF MOTHER: Ruth Martin

[13] BIRTHPLACE OF MOTHER (State or country): St. Mary's County, Md.

[14] THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick Geddes

(Address) Drayden, Md.

[15] Filed Feb. 4, 1920 Harrison Hall
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

[16] DATE OF DEATH: Jan. (Month) 31 (Day) 1920 (Year)

[17] I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1920, to Jan. 31st, 1920, that I last saw him alive on Jan. 30, 1920, and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH * was as follows:

Influenza

(Duration) — yrs. — mos. 1 ds.

Contributory Secondary

Broncho-Pneumonia (Duration) — yrs. — mos. 3 ds.

(Signed) L. Harper Lynch M. D.

Feb. 1st, 1920 (Address) Valley Lee, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

[18] LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In this State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

[19] PLACE OF BURIAL OR REMOVAL: Rutherford Church

DATE OF BURIAL: Feb. 2, 1920

[20] UNDERTAKER: Lewis T. Clarke

ADDRESS: Great Mills, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*, *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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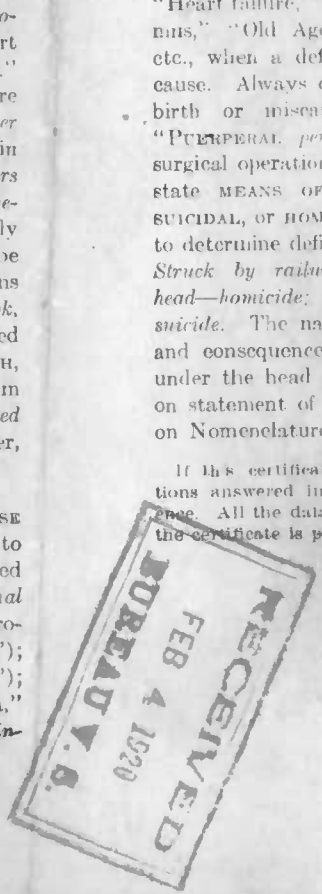

V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 287

894 (108)

[1] PLACE OF DEATH

County St Marys

Village or City California (No. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

[2] FULL NAME John Thomas Torney

PERSONAL AND STATISTICAL PARTICULARS

[3] SEX: Male

[4] COLOR OR RACE: Black

[5] SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

[6] DATE OF BIRTH: — — , 1901 (Month) (Day) (Year)

[7] AGE: 18 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. OR ..... min. ?

[8] OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Saw Mill

[9] BIRTHPLACE (State or country): Maryland

PARENTS

[10] NAME OF FATHER: James Torney

[11] BIRTHPLACE OF FATHER (State or country): Maryland

[12] MAIDEN NAME OF MOTHER: Mary Barber

[13] BIRTHPLACE OF MOTHER (State or country): Maryland

[14] THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George K. Torney

(Address) California Md

[15] Filed Jan 28, 1920 Jos. E. Hayward Dept REGISTRAR

MEDICAL CERTIFICATE OF DEATH

[16] DATE OF DEATH: Jan (Month) 27 (Day), 1920 (Year)

[17] I HEREBY CERTIFY, That I attended deceased from Jan 25, 1920, to Jan 27, 1920, that I last saw h— alive on Jan 25, 1920 and that death occurred on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis due to rupture of appendix

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory Secondary: Chronic appendicitis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) ..... , M. D.

Jan 28, 1920 (Address) Jarboesville, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

[18] LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds

Where was disease contracted, if not at place of death?

Former or usual residence

[19] PLACE OF BURIAL OR REMOVAL: St Johns Church — DATE OF BURIAL: Jan 28, 1920

[20] UNDERTAKER: Bud Caard — ADDRESS: Great Mills

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup";) *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

895 (D)

Registration Dist. No. 282

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County St Mary's

Village or City Sellers (No. ____, ____ St.; ____ Ward)

2 FULL NAME Still Born

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	Black	Sgl

6 DATE OF BIRTH: Jan (Month) 23 (Day), 1920 (Year)

7 AGE: 0 yrs. 0 mos. 0 ds. If LESS than 1 day, X hrs. OR ____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: John T. Weldon

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Nora Banks

13 BIRTHPLACE OF MOTHER (State or country): Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno. T. Weldon

(Address) Sellers

15 Filed Jan 26, 1920 E. E. Birch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 23 (Day), 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ____, 191__, to ____, 191__, that I last saw h__ alive on ____, 191__, and that death occurred on the date stated above, at ____ m.

The CAUSE OF DEATH * was as follows:

By still Born

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. O. Tracy, M. D.

Jan 23, 1920 (Address) Ridge Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Fursies Cemetery	Jan 24, 1920

20 UNDERTAKER	ADDRESS
Jno T. Weldon	Sellers

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

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RECEIVED
FEB 9 1920
BUREAU V.S.